Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28380 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation and resurvey conducted in your facility from 10/20/09 to 11/2/09. This State Licensure complaint and survey were conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received the grade of D. The facility is licensed for 150 beds, 120 Residential Facility for Group beds for elderly and disabled persons, chronic illnesses, mental illnesses, and 30 beds for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 132 and thirty resident files were reviewed. The facility had 35 residents residing in the portion of the facility licensed for 30 residents with Alzheimer's disease or other related dementia's. The facility was over census in this unit. Immediate Jeopardy was identified on 10/21/09 at 2:30 PM for TAG Y878 Administration of Medications. The the facility provided an acceptable plan for correction of the Immediate Jeopardy on 10/23/09. Complaints #NV00023339, NV00023355 and NV00023497 were substantiated. See TAGs Y515, Y813, Y850, Y878 and Y895.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Continued From page 1 The following deficiencies were identified:	Y 000		
Y 050 SS=J	449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. This Regulation is not met as evidenced by: Surveyor: 21044 Based on interview, record review and observation from 10/20/09 to 11/2/09, the administrator failed to provide oversight and direction to the staff to ensure residents received needed services and protective supervision, and to ensure the facility was in compliance with the regulations for a Residential Facility for Groups. Findings include: The administrator failed to ensure Residents #21, #24 and #26 received the care they required to prevent hospitalization (Refer to TAGs Y590 and	Y 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 050	Continued From page 2 Y878). The administrator, Employee #2, failed to ensure accurate medication administration for 24 of 30 residents (Refer to TAGs Y878 and Y895). The administrator failed to ensure when admitted, Resident #18, #30 and #31 the facility could provide the care they required (Refer to TAGs Y720, Y743, Y773 and Y775). The administrator failed to to ensure Resident #1 was provided with the necessary protective supervision to prevent the resident from trying to leave the facility unattended (Refer to TAG Y515 and Y813). The administrator admitted too many residents to the memory care unit and the unit was found to be over census on 10/20/09 and 10/23/09 (Refer to TAG Y087). The administrator failed to ensure the facility was maintained in a manner to a quality dining experience for all residents in the facility (Refer to TAG Y178). Severity: 4 Scope: 1	Y 050		
Y 087 SS=F	449.199(3) Limitation on Number of Residents NAC 449.199 3. A residential facility must not accept residents in excess of the number of residents specified on the license issued to the owner of the facility.	Y 087		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 087	Continued From page 3 This Regulation is not met as evidenced by: Surveyor: 28380 Based on record review from 10/20/09 to 10/23/09, the memory care unit was over census and the facility intentionally violated the provisions of its license. The limitation on census is intended to ensure residents of this unit receive appropriate oversight by staff and admitting more residents into the unit risks patient safety. Findings include: The facility's memory care unit is licensed for 30 beds. Based on the census report provided by the facility on 10/20/09, there were 35 residents residing in the memory care unit. On 10/23/09, the Executive Director admitted there were 33 residents residing in the unit. This was a repeat deficiency from the 9/24/09 State Licensure survey. Severity: 2 Scope: 3	Y 087		
Y 178 SS=F	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This Regulation is not met as evidenced by: Surveyor: 28276	Y 178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 178	Continued From page 4 Based on observation and interview from 10/20/09 through 11/2/09, the facility failed to ensure repairs to the dining were completed in a timely manner and to ensure the facility was well maintained for the residents of the facility. Findings include: A report from the Southern Nevada Health District (SNHD) dated 9/27/09 documented they responded to a flood in the kitchen of the facility at 6:15 AM. The document revealed that per the Las Vegas Fire Department the facility had a water line break. The facility was not permitted with the SNHD, so the SNHD recommended the facility close the kitchen and begin cleaning and sanitizing the area and contact the State Health Division, Bureau of Health Care Quality and Compliance. An onsite visit was conducted 9/28/09 by the Bureau and an Inspection Report Form was completed. The form documented the facility had a leak on 9/27/09 which had been repaired as well as the other associated repairs to the fire protection system. The kitchen had been cleaned and sanitized and the dining room closed. Residents were being served meals in the facility's lobby with food delivered from area restaurants and from a reduced menu from the facility's kitchen. On 9/28/09, a mold remediation company was on site and estimated one week to remove and repair the affected ceiling tiles, walls and carpet in the dining room. An e-mail to the Chief Operating Officer (COO) dated 10/6/09 documented a phone call	Y 178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 178	Continued From page 5 discussing the situation with the dining room. The e-mail documented the facility's dining room was still closed due the need to special order ceiling tiles that would meet fire codes. The e-mail documented that the kitchen was in full operation and the residents were being served their meals (regular menu) in auxiliary areas. The facility anticipated the dining room would be completed in approximately 10 days. The COO responded on 10/7/09, relating that she called the facility concerning the progress on the dining room and was still awaiting a response. During the complaint investigation on 10/20/09, surveyors observed residents being served meals in the facility lobby and adjoining rooms. Staff reported the dining room was still under construction. The COO, Employee #2, who was on duty at the facility, reported the construction company had "walked off the job" and a new construction company was being sought out to complete the work. On 10/21/09, the COO sent an e-mail to the Bureau stating the construction would begin again on 10/22/09. On 11/1/09, the Bureau sent an e-mail to the COO asking if the repairs had begun. The COO responded they had not and would check on the progress. On 11/3/09, the COO sent an e-mail reporting the construction company was putting in the dry wall and then the facility needed to be inspected by the fire department. As of 11/2/09, the facility's dining room had not be re-opened. Severity: 2 Scope: 3	Y 178		
Y 515 SS=F	449.259(1)(a) Supervision of Residents	Y 515		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 515	Continued From page 6 NAC 449.259 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary. This Regulation is not met as evidenced by: Surveyor: 28380 Based on observation and interview from 10/20/09 to 10/23/09, the facility failed to provide protective supervision for 35 of 35 memory care residents to prevent residents from leaving the facility unattended. Findings include: A kitchen-type chair was left next to the metal fence that surrounded the outside patio of the memory care unit. It was reported one of the memory care residents sat in the chair daily. It was also discovered Resident #1 used the chair on two occasions to climb over the fence during attempts to leave the facility. A caregiver observed the resident on the other side of the fence and was able to bring her back into the facility. This was a repeat deficiency from the 7/29/09 Complaint Investigation. Severity: 2 Scope: 3	Y 515		
Y 590 SS=J	449.268(1)(a) Resident Rights NAC 449.268	Y 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 590	Continued From page 7 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by: Surveyor: 21044 Based on record review and interview from 10/20/09 to 11/2/09, the facility neglected 24 of 30 residents by not ensuring they received medications as prescribed from 10/1/09 through 11/2/09 (Resident #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26 and # 28); and 3 of the 30 residents were hospitalized due the facility's failure to administer medications as prescribed (Residents #21, #24 and #26). Findings include: The facility did not have medications available for one or more residents from 10/1/09 through 11/2/09. Residents #21, #24 and #26 were transferred from the facility to the hospital. The records for Resident #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26 and #28, showed they did not receive their medications as prescribed between 10/1/09 through 11/2/09. Refer to TAG Y878. Severity: 4 Scope: 1	Y 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 720	Continued From page 8	Y 720		
Y 720 SS=F	449.2716(1)(a)(b) 449.2716(1)(a) Colostomy / Ileostomy NAC 449.2716 1. A person who has a colostomy or ileostomy must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident is mentally and physically capable of properly caring for his colostomy or ileostomy, with or without assistance, and the resident's physician has stated in writing that the colostomy or ileostomy is completely healed. (b) The care for the colostomy or ileostomy is provided by a medical professional who is trained to provide that care. This Regulation is not met as evidenced by: Surveyor: 28276 Based on interview on 10/29/09, the facility failed to ensure 1 of 2 residents with a colostomy was mentally and physically capable of properly caring for the colostomy bag (Resident #31). Findings include: Interview with Employee #1 revealed caregivers were assisting Resident #31 with her colostomy bag. The resident was living in the facility's memory care unit, had dementia and was unable to care for her colostomy. This is a violation because a person who has a colostomy or ileostomy must not be admitted to a	Y 720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 720	Continued From page 9 residential facility or be permitted to remain as a resident of a residential facility unless the resident is mentally and physically capable of properly caring for his colostomy or ileostomy. The resident's physician must state in writing that the colostomy or ileostomy is completely healed and that the care for the colostomy or ileostomy can be provided by the resident or by a medical professions who is trained to provide that care. The caregivers providing assistance were not trained medical professionals. Severity: 2 Scope: 3	Y 720		
Y 743 SS=F	449.272(2) Indwelling Catheters NAC 449.272 2. The caregivers employed by a residential facility with a resident who requires the use of an indwelling catheter shall ensure that: (a) The bag and tubing of the catheter are changed by: (1) The resident, with or without the assistance of a caregiver. (2) A medical professional who has been trained to provide that care. (b) Waste from the use of the catheter is disposed of properly. (c) Privacy is afforded to the resident while care is being provided; and (d) The bag of the catheter is emptied by a caregiver who has received instruction in the handling of such waste and the signs and symptoms of urinary tract infections and dehydration.	Y 743		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 743	Continued From page 10 This Regulation is not met as evidenced by: Surveyor: 28276 Based on interview on 11/2/09, the facility failed to ensure staff who provided care to 1 of 1 residents with an indwelling catheter had the training required by NAC 449.272 (Resident #18). Findings include: On 11/2/09 at 7:08 AM, Employee #1 stated Resident #18 had an indwelling catheter. The employee reported she was required to assist the resident with emptying the urine from the catheter bag. The employee was unable to answer questions related to the signs and symptoms of urinary tract infections and dehydration. There was no evidence the employee had received training on this subject. Severity: 2 Scope: 3	Y 743		
Y 773 SS=F	449.2726(1)(a)(1)(2) 449.2726(1)(a)(b) Diabetes NAC 449.2726 1. A person who has diabetes must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident's glucose testing is performed by: (1) The resident himself, without assistance; or (2) A medical laboratory licensed pursuant to chapter 652 of NRS; and	Y 773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 773	Continued From page 11 This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation and interview on 10/25/09, the facility did not ensure blood glucose testing for 1 of 2 diabetic residents was performed by the residents themselves without assistance (Resident #30). Findings include: Employee #3 was observed to perform blood glucose testing on Resident #30 at 11:02 AM on 10/25/09. Employee #3 stated the medication technicians on the morning and evening shifts perform this function for the resident. This is a violation because a person who has diabetes must not be admitted to a residential facility or permitted to remain as a resident unless the resident's blood glucose testing is performed by the resident without assistance or have the testing done by a medical professional. The caregiver who performed the blood sugar testing on Resident #30 was not a medical professional. Severity: 2 Scope: 3	Y 773		
Y 775 SS=F	449.2726(1)(b)(1) Residents having diabetes 1. A person who has diabetes must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (b) The resident's medication is administered: (1) By the resident himself without assistance;	Y 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 775	Continued From page 12 This Regulation is not met as evidenced by: Surveyor: 28276 Based on staff interviews on 10/25/09, the facility did not ensure 1 of 2 residents prescribed insulin administered the medication themselves without assistance (Resident #30). Findings include: Employee #4 stated the medication technicians on the evening shift draw insulin into a syringe and inject the insulin into Resident #30. This is a violation because a person who has diabetes must not be admitted to a residential facility or permitted to remain as a resident unless the resident's insulin is administered by the resident without assistance. The caregivers injecting the resident were not medical professionals. Severity: 2 Scope: 3	Y 775		
Y 813 SS=G	449.2732(1)(d) Protective Supervision NAC 449.2732 1. Except as otherwise provided in subsection 2, a person who requires protective supervision may not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (d) The caregivers employed by the facility can meet the needs of the resident.	Y 813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 813	Continued From page 13 This Regulation is not met as evidenced by: Surveyor: 11456 Based on observation and record review on 10/20/09, the facility failed to provide necessary protective supervision for 1 of 35 memory care unit residents (Resident #1). Findings include: Facility records documented two occasions Resident #1 use a chair to climb over the 6-foot fence of the memory care unit in attempts to leave the facility unattended. The resident had access to the chair as it was left next to the fence near to pillar by facility staff. Staff observed the resident going over the fence the second time and were able to escort the resident back into the facility (Refer to TAG Y515). Severity: 3 Scope: 1	Y 813		
Y 850 SS=C	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not	Y 850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 850	Continued From page 14 available. This Regulation is not met as evidenced by: Surveyor: 28380 Based on interview and record review from 10/20/09 to 10/23/09, the facility failed to ensure 1 of 1 resident's guardians were notified when the resident was admitted to the hospital(Resident #2). Severity: 1 Scope: 3	Y 850		
Y 878 SS=J	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Surveyor: 28380	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 15 Based on record review and interview from 10/20/09 to 11/2/09, the facility neglected to ensure that 24 of 30 residents received medications as prescribed from 10/1/09 - 11/2/09(Resident #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26 and # 28); and 3 of 30 residents were hospitalized due to the facility's failure to administer medications as prescribed from September through October 2009 (Residents #21, #24 and #26). Findings include: A complaint investigation was conducted at the facility on 9/23/-24/09. During the investigation it was determined there were residents who were not receiving their medications as prescribed by their physician because the medications were not available in the facility. Medications were not available due to lack of payment to the pharmacy by residents, failure of families to provide refills of resident medications, and failure by the facility to ensure resident medications were refilled. On 9/24/09, the Executive Director, Employee #9, was informed that the findings of the investigation were an immediate jeopardy situation that would require immediate correction by the facility. The Executive Director initiated corrections by calling resident families, calling pharmacies for refills and coordinating delivery of medications to the facility. In addition, the Executive Director wrote a policy letter dated 9/24/09 that indicated the facility would ensure that a working relationship with a pharmacy would be established to provide all necessary resident medications to residents that failed to provide their own medications. The letter indicated the facility would incur the cost of medications and bill the resident and/or a	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 16 responsible party on the monthly statement. The letter also included a policy on medication requests and evidence that an in-service had been conducted with four staff persons on 9/24/09 regarding the new policy. The policy on medication requests indicated that: - All resident medications would be requested by the medication technician from the appropriate pharmacy within seven to ten days prior to administration of the last dose. - Each medication delivery would be checked against the medication re-order form to ensure receipt of all medications by the medication technicians. Medications that were not received within five days prior to administration of the last dose would be followed up by the medication technician by calling the pharmacy. The medication technician would follow up with appropriate action to ensure that the requested medication was received prior to the last dose. - The midnight shift medication technicians would complete nightly medication chart audits to ensure all medications were ordered in compliance with the facility's policy. - All resident medications would be requested by the medication technician from the appropriate family member within seven to ten days prior to administration of the last dose. The medication requests would be documented in the medication reorder/receipt binder. - Each medication delivery would be checked against the medication re-order form to ensure receipt of all medications by the medication technicians. Medications that were not received within five days prior to administration of the last	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 17 dose would be followed up by the medication technician who would call the family. The medication technician would follow up with appropriate action to ensure that the requested medication was received prior to the last dose. - Upon admission, the responsible party and/or resident would sign the facility's pharmacy agreement authorizing the facility to order all medications that were not provided by the resident or for the resident by the family. - In the event the pharmacy or family failed to comply with the reorder request, the Wellness Director would ensure follow up with the primary care physician and Executive Director. During a complaint investigation and re-survey conducted from 10/20/09 through 11/2/09, it was determined the facility was not following its stated plan for correction of medication deficiencies found during the 9/23-24/09 survey. The facility's computerized medication administration records (MARs) were not being completed consistently or accurately by the facility's medication technicians. Resident medications were not being refilled to ensure there would be replacement medications when the month's supply ran out. Resident's medication prescriptions were allowed to expire without physician appointments being made for to acquire updated prescriptions. The facility admitted that they did not have primary physician information for many residents who were admitted to the facility from a hospital. Staff reported the wireless computer system often did not operate and staff would have to print daily paper MARs to record the day's medication administrations. This made it more difficult for staff to track changes to resident medication	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 18 orders and daily medication administration to residents. Administration of "as needed" or PRN medications were not being documented on the paper MARs as there was not a printed area for PRNs. There was no evidence medication audits were being completed by the night shift medication technicians and there was only recent evidence that medication delivery logs were being maintained. The computerized MARs explanation codes listed at the bottom of each MAR were used by staff to explain why a resident did not receive a medication. Comparison the computerized MARs between residents and between the months of September and October revealed that a numbered reason for a resident missing a medication on one MAR would not have the same meaning on another MAR. There was no way to determine if the medication technicians were aware of the inconsistency between MARs and were therefore accurately describing the missed medication event. There inconsistencies in the October and November 2009 MARs between the medication dosages and administration instructions versus the dosages and administration instructions on the prescription container labels. There were frequent errors in documentation by the medication technicians as they failed to initial that a medication had been given to a resident, leaving the MAR blank for that day or time of day, or initialing they gave a medication on days when the facility was out of the medication or the resident was out of the facility. The medication technicians frequently indicated residents "refused" or were asleep for their PM/evening or bedtime medications. During interviews with residents who were to receive the medications it was reported the medication	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 19 technicians were bringing the medications to the residents too late, sometimes at 11:00 PM instead of 8:00 PM, or not at all. There were medication technicians who reported being aware of other technicians who disposed of medications in the facility Sharp's containers because they said they did not have time to get them to the residents. A former Wellness Director, who was a registered nurse, stated the facility's policy was to dispose of expired and discontinued medications in the large Sharp's containers, and the containers would then be removed from the facility. The Wellness Director reported she found out medication technicians were also throwing resident medications in the Sharp's containers when they did not have time to administer them. The registered nurse stated she resigned because she was fearful of having her nursing license revoked due to this and other bad practices of staff and facility management. Two large Sharp's containers were observed filled with hundreds of pills, with three additional large Sharp's containers partially filled with pills. Photographs were taken of the containers. A sample of 30 resident medication records were reviewed during the complaint investigation from 10/20-21/09. It was determined the records contained had significant medication errors. The new Executive Director, Employee #1, and the administrator, Employee #2, were informed of the second immediate jeopardy situation on 10/21/09 and the need for immediate action for the correction of the deficiencies. The facility conducted a medication audit on 10/21/09 and 10/22/09 of residents with missing medications. When the large percentage of residents missing medications was discussed with the new Executive Director, the director reported "that 100 percent of the residents that required medication	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 20	Y 878		

assistance were missing medications." An additional audit conducted on 10/23/09 by the facility indicated that 68 out of 126 residents currently residing in the facility were missing medications and some residents were missing multiple medications.

The survey was extended and additional residents were added to the sample 10/22/09 to 11/2/09. It was determined 24 of the 30 resident medication records had significant medication errors. It was also determined that from 10/1/09 to 11/2/09, one or more residents did not have one or more medications available in the facility on each day of that 33 days period.

Seven residents went from the facility to the hospital in September and October 2009. Three of those residents, Residents #21, #24 and #26, needed to be hospitalized due to the facility's failure to administer their medications as prescribed. Reviews of three resident's September, October and November 2009 records revealed the following:

Resident #21: A University Medical Center Quick Care medical record indicated Resident #21 was seen and evaluated for nausea, vomiting and dehydration on 10/21/09. The resident reported his nausea, vomiting was intermittent over the past month. The resident was diagnosed with dehydration and a urinary tract infection and transferred to a long term care facility for continued in-patient care and physical therapy.

A review of Resident #21's MAR for September 2009 revealed the resident's Ranitidine medication, prescribed twice a day for gastric ulcers and GERD, was not administered 22 times during the month. The resident's Reglan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 21 medication, prescribed four-times daily before meals for prevention of nausea and vomiting, was not administered 48 times in September and October of 2009. The resident's Flagyl medication, prescribed three times a day for six days for treatment of gastrointestinal infections, was listed as unavailable from 9/1/09 to 9/20/09 on the September MAR. The facility's failure to administer gastrointestinal medications to the resident on a consistent basis was determined to be a contributing factor to the resident's intermittent complaints of nausea and vomiting for the past month and most likely was a contributing factor to the resident having to go to the hospital on 10/21/09. Resident #21 MAR also showed the following medication errors: ASA 81 milligram (mg), one time a day (a blood thinner). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/1/09. Ceftin 250 mg, two times a day (an antibiotic). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/2/09 (8:00 PM) Lactinex, three times a day -AM, Noon and PM (a digestive aid). The medication technicians noted on the October MAR the medication was not available in the facility for 29 doses: - three doses on 10/1/09 (AM, noon and PM) - two doses on 10/3/09 (noon and PM) - one dose on 10/5/09 (PM) - three doses on 10/6/09 (AM, noon, and PM) - three doses on 10/7/09 (AM, noon, and PM) - one dose on 10/8/09 (PM)	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 22 - one dose on 10/9/09 (PM) - one dose on 10/10/09 (PM) - three doses on 10/11/09 (AM, noon and PM) - three doses on 10/12/09 (AM, noon and PM) - two doses on 10/13/09 (AM and PM) - three doses on 10/14/09 (AM, noon and PM) - two doses on 10/15/09 (AM and PM) - one dose on 10/21/09 (AM) The medication technicians initialed they gave this medication on days the medication was documented as not available in the facility. The documentation does not confirm the medication was given to the resident. Multivitamin one time a day. The medication technicians noted on the October MAR the medication was not available in the facility for: - four doses (10/1/09, 10/6/09, 10/7/09 and 10/11/09). Reglan 10 mg, four times a day (for gastroesophageal reflux disease (GERD) - 41 doses. The medication technicians noted on the October MAR the medication was not available in the facility for 42 doses: - three doses on 10/1/09 (11:00 AM, 3:00 PM and 8:00 PM) - two doses on 10/2/09 (3:00 PM and 8:00 PM) - two doses on 10/3/09 (3:00 PM and 9:00 PM) - two doses on 10/4/09 (3:00 PM and 8:00 PM) - two doses on 10/5/09 (3:00 PM and 9:00 PM) - three doses on 10/6/09 (11:00 AM, 3:00 PM and 8:00 PM) - four doses on 10/7/09 (7:00 AM, 11:00 AM, 3:00 PM and 8:00 PM) - two doses on 10/8/09 (3:00 PM and 8:00 PM) - three doses on 10/9/09 (7:00 AM, 3:00 PM and	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 23 8:00 PM) - one dose on 10/10/09 (11:00 PM) - two doses on 10/11/09 (7:00 AM and 11:00 AM) - one dose on 10/12/09 (11:00 AM) - two doses on 10/13/09 (3:00 PM and 8:00 PM) - two doses on 10/14/09 (11:00 AM and 3:00 PM) - two doses on 10/15/09 (3:00 PM and 8:00 PM) - three doses on 10/18/09 (7:00 AM, 11:00 AM and 3:00 PM) - two doses on 10/19/09 (11:00 AM and 3:00 PM) - two doses on 10/20/09 (11:00 AM and 3:00 PM) - two doses on 10/21/09 (7:00 AM and 11:00 AM). Resident #24: Summerlin Emergency Room records indicated Resident #24 was sent from the facility on 8/7/09 and was evaluated in the emergency room for cellulitis in both lower extremities. The resident's past medical history included alcoholism, dementia and Alzheimer's disease. The resident was prescribed Keflex and Bactrim, antibiotics for treatment of cellulitis. Resident #24's August and September 2009 MARs indicated the resident refused 22 doses of Keflex and did not complete the antibiotic therapy prescribed by the physician. The resident was transferred back to Valley Hospital on 9/16/09 with a diagnosis of bilateral lower extremity cellulitis. There was no documented evidence that the facility notified or called the resident's physician concerning the resident refusing her antibiotic therapy. The resident's second hospitalization at Valley Hospital for cellulitis was associated with the inconsistency of the antibiotic treatment while at the facility. On 9/26/09, Resident #24 received prescriptions for Lasix 20 mg, a Multivitamin, and Potassium Chloride 10 meq but the medications were not	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 24 started until 10/12/09 - a 16 day delay. The resident was also prescribed Levaquin 250 mg on 10/10/09, but the October MAR indicated the medication was not started until 10/15/09 - a five day delay. Resident #24 was prescribed Maxzide 25 mg, one time a day (reduces fluid retention in edema and high blood pressure). The medication technicians noted on the October MAR that the medication was not available in the facility for two doses on 10/4/09 and 10/11/09. Resident #26: The resident went to the hospital on 9/15/09 and has not returned to the facility. A Summerlin Hospital Admission History and Physical dated 9/15/09 indicated Resident #26 was an 89 year old female who was transferred from the facility for altered mental status and repeated (four) falls. The resident had a history of seizures, pulmonary embolus, atrial fibrillation, congestive heart failure, hypertension, chronic obstructive pulmonary disease (COPD), depression and gastroesophageal reflux disease (GERD). When seen at the hospital on 9/15/09, Resident #26 was in atrial fibrillation with a rate in the 100s. She was seen by cardiology and medications were adjusted. The resident also had evidence of a stroke and some left sided weakness. The resident was admitted for further evaluation, physical therapy, rehabilitation and management of congestive heart failure. The resident's blood pressure on admission was 161/101, pulse 101, irregular rate and rhythm, respirations 16. The resident was treated and transferred to Desert Lane Care Center, then to Silver Ridge Healthcare Center on 9/18/09.	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 25 A review of MAR for Resident #26 revealed the resident's Carveilol medication, prescribed twice a day to treat hypertension and congestive heart failure, was not given on 9/7/09 nor on 9/14/09, one day prior to her transfer to the hospital. The resident's Digoxin medication, prescribed once a day and used to treat congestive heart failure and atrial fibrillation, was not given on 9/7/09 nor on 9/14/09, one day prior to the resident's transfer to the hospital. The resident's Diltiazem medication, prescribed once daily and used to treat atrial fibrillation and hypertension, was not given on 9/0/09 nor on 9/14/09, one day prior to the resident's transfer to the hospital for complications of atrial fibrillation and congestive heart failure. In addition, the September 2009 MAR for Resident #26 documented by staff's initials that the resident received all her medications on 9/15/09, 9/16/09 and 9/17/09 when the resident was actually in the hospital and no longer in the facility. On admission to the hospital on 9/15/09, Resident #26 was found to be in congestive heart failure and suffering from atrial fibrillation. The resident was found to have left sided weakness and possible stroke. Chancellor Gardens' failure to administer the resident's cardiac medication was a contributing factor to her needing hospitalization and treatment. The reviews of the October and November 2009 MARs up to 11/2/09 for Residents #2, #3, #4, #5, #6, #7, #8,#9,#10, #11, #13, #15, #16, #17, #18, #19, #20, #22, #23, #25 and #28 revealed the following: Resident #2:	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 26 Isosorbide Mononitrate ER 60 mg, one tablet every day (for chest pain). The medication technicians noted on the October MAR that the facility did not have the medication available for one dose on 10/23/09. Aricept 5 mg, one tablet every day (for mild to moderate dementia) The medication technicians noted on the October MAR that the facility did not have the medication available for one dose on 10/23/09. Resident #3: Carbidopa /Levodopa 25/100 mg, one tablet five times a day at 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM (for Parkinson ' s disease). The medication technicians left the October and November MAR blank for 33 doses between 10/1/09 and 10/25/09. The facility's documentation does not confirm the medication was given to the resident. Temazepam 15 mg, as needed (for insomnia). The medication technicians noted the medication was not available if needed by the resident for 21 days from 10/1/09 through 10/21/09. Azilect 1 mg, one time a day at 8:00 AM (for Parkinson ' s disease). The medication technicians left the October and November MAR blank for six doses between 10/2/09 and 11/2/09. The facility's documentation does not confirm the medication was given to the resident. Resident #4: Aricept 10 mg, one time a day at 8:00 AM (for mild to moderate dementia). The medication technicians noted on the October MAR that the facility did not have the medication	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 27 available for 21 doses (10/1/09, 10/2/09, 10/3/09, 10/4/09, 10/5/09, 10/6/09, 10/7/09, 10/8/09, 10/10/09, 10/11/09, 10/12/09, 10/13/09, 10/14/09, 10/15/09, 10/16/09, 10/18/09, 10/19/09, 10/20/09, 10/23/09, 10/24/09, 10/25/09, 10/26/09 and 10/27/09). The medication technicians left the October MAR blank for five doses between 10/2/09 and 10/21/09. It was noted the days the October 2009 MAR was not initialed were interspersed with days the medication was documented as not available. Without documentation, it is not clear whether the medication was also unavailable on these dates or was not given for some other reason. The medication was discontinued by the resident's physician on 10/28/09. Namenda 10 mg, two times a day at 8:00 AM and 5:00 PM. (for Alzheimer ' s related dementia) The medication technicians left the October and November MAR blank for 13 doses between 10/1/09 (5 PM) and 11/1/09 (5 PM). The documentation does not confirm the medication was given to the resident. Evista 60 mg, one time a day at 8:00 AM (for osteoporosis). The medication technicians noted on the October MAR the medication was not available in the facility for: - 16 doses (10/1/09, 10/4/09, 10/5/09, 10/6/09, 10/7/09, 10/8/09, 10/11/09, 10/12/09, 10/13/09, 10/14/09, 10/15/09, 10/16/09, 10/19/09, 10/20/09, 10/23/09 and 10/24/09) The medication technicians left the October MAR blank for six doses between 10/2/09 and 10/21/09. It was noted the days the October 2009 MAR was not initialed were interspersed with	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 28 days the medication was documented as not available. Without documentation, it is not clear whether the medication was also unavailable on these dates or was not given for some other reason. Trazadone 50 mg, 1.5 tablets one time a day given at bedtime (for insomnia and/or depression). The medication technicians noted on the October MAR the medication was not available in the facility for 19 doses (10/5/09, 10/6/09, 10/7/09, 10/11/09, 10/13/09, 10/14/09, 10/15/09, 10/17/09, 10/18/09, 10/19/09, 10/22/09, 10/23/09, 10/24/09, 10/25/09, 10/27/09, 10/28/09, 10/29/09, 10/30/09, 10/31/09). The medication technicians left the October and November MARs blank for seven doses between 10/1/09, 10/2/09, 10/3/09, 10/4/09, 10/9/09, 10/10/09, 10/20/09, 10/26/09 and 11/1/09. It was noted the days the October and November 2009 MARs were not initialed were interspersed with days the medication was documented as not available. Without documentation, it is not clear whether the medication was also unavailable on these dates or was not given for some other reason. Maxzide 37.5-25 mg, one time a day at 8:00 AM (reduces fluid retention in edema or high blood pressure). The medication technicians left the October MAR blank for five doses between 10/2/09 and 10/17/09. The documentation does not confirm the medication was given to the resident. Colace 100 mg, two times a day, 8:00 AM and 8:00 PM (a stool softener or laxative). The medication technicians left the October and	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 29 November MARs blank for 11 doses between 10/1/09 (8:00 PM) and 10/20/09 (8:00 PM). The documentation does not confirm the medication was given to the resident. After the survey on 10/22/09, the medication technicians documented the resident refused to take her medication or missed taking the medication for an undocumented reason for: - one dose on 10/22/09 (8:00 PM) - two doses on 10/23/09 (8:00 AM and 8:00 PM) - two doses on 10/24/09 (8:00 AM and 8:00 PM) - two doses on 10/25/09 (8:00 AM and 8:00 PM) Lovastatin 40 mg, one tab at bedtime (for high cholesterol). The medication technicians left the October and November MARs blank for nine doses between 10/1/09 and 11/1/09. The documentation does not confirm the medication was given to the resident. Aspirin 325 mg, one tablet every day (a pain reliever). The medication technicians left the October MAR blank for one dose on 10/24/09. The documentation does not confirm the medication was given to the resident. Oyster Shell Calcium with Vitamin D 500 mg, take one tablet twice a day (for prevention or treatment of a calcium deficiency). The medication technicians left the October and November MARs blank for two doses on 10/26/09 (PM) and 11/1/09 (PM). The documentation does not confirm the medication was given to the resident. Resident #5: Lorazepam 0.5 mg, as needed (for anxiety).	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 30 The medication technicians noted on the October MAR that the medication was not available if needed for nine days from 10/13/09 through 10/21/09. It was noted on 11/2/09 that the medication was available in the facility. Docusate Sodium 100 mg, two times a day, 8:00 AM and 8:00 PM (for constipation). The medication technicians left the October MAR blank for four doses from 10/16/09 (8:00 AM) and 10/21/09 (8:00 AM). The documentation does not confirm the medication was given to the resident. The medication technicians noted that the resident "refused" the 8:00 PM dose on 10/23/09. Certagen 0.4-18-250, one time a day at 8:00 AM (a multivitamin). The medication technicians left the October MAR blank for two doses on 10/17/09 and 10/21/09. The documentation does not confirm the medication was given to the resident. Resident #6: Risperidone 3 mg, two times a day (for schizophrenia or bipolar disorder). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for ten doses from 10/1/09 (5:00 PM) to 10/20/09 (5:00 PM). The documentation does not confirm the medication was given to the resident. Lisinopril 20 mg, two times a day (for high blood pressure). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for eleven doses from 10/1/09 (5:00 PM) to 10/20/09 (5:00 PM). The documentation does not confirm the medication	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 31 was given to the resident. Loxapine Succinate 50 mg, two times a day (for psychotic disorders). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for ten doses from 10/1/09 (5:00 PM) to 10/20/09 (5:00 PM). The documentation does not confirm the medication was given to the resident. Docusate NA 100 mg, two times a day (for constipation). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for eleven doses from 10/1/09 (5:00 PM) to 10/20/09 (5:00 PM). The documentation does not confirm the medication was given to the resident. Seroquel 200 mg, three times a day (an antipsychotic). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for eleven doses from 10/1/09 (5:00 PM) to 10/20/09 (noon and 5:00 PM). The documentation does not confirm the medication was given to the resident. Vistaril 25 mg, two times a day (for anxiety). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for ten doses from 10/1/09 (5:00 PM) to 10/20/09 (5:00 PM). The documentation does not confirm the medication was given to the resident. Risperdal 50 mg, one time a day (an antipsychotic). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for four	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 32 doses from 10/2/09 to 10/17/09. The documentation does not confirm the medication was given to the resident. Metoprolol Tartrate 25 mg, two times a day (for high blood pressure). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for ten doses from 10/1/09 (5:00 PM) to 10/20/09 (5:00 PM). The documentation does not confirm the medication was given to the resident. During staff interviews on 11/2/09, it was reported the resident refused to take all medications from 10/26/09 through 11/2/09. The facility is in the process of changing the resident's doctor, so there was no physician notified of the medication refusals. Resident #7: Lovastatin 20 mg, one time a day at 8:00 PM. (for high cholesterol). The medication was not available in the facility on 10/20/09. The medication technicians noted on the October MAR the medication was not available in the facility for: - 17 doses (10/5/09, 10/6/09, 10/7/09, 10/10/09, 10/11/09, 10/12/09, 10/ 13/09, 10/14/09, 10/16/09, 10/18/09, 10/19/09, 10/23/09, 10/24/09, 10/25/09, 10/26/09, 10/27/09, 10/28/09). The medication technicians left the October MAR blank for six doses from 10/1/09, to 10/29/09). It was noted the days the October 2009 MAR was not initialed were interspersed with days the medication was documented as not available. Without documentation, it is not clear whether the medication was also unavailable on these dates or was not given for some other reason.	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 33 Omeprazole 20 mg, one time a day at 8:00 AM (to reduce stomach acid). The medication technicians noted on the October MAR the medication was not available in the facility for: - five doses (10/24/09, 10/25/09, 10/26/09, 10/27/09 and 10/28/09) The medication technicians left the October MAR blank for five doses from 10/2/09 to 10/21/09). The documentation does not confirm the medication was given to the resident. Thiamine 100 mg, one time a day at 8:00 AM (for Vitamin B1 deficiency). The medication was not available in the facility on 10/20/09. The medication technicians noted on the October MAR the medication was not available in the facility for: - nine doses (10/11/09, 10/12/09, 10/ 13/09, 10/14/09, 10/15/09, 10/16/09, 10/18/09, 10/19/09 and 10/20/09). The medication technicians left the October MAR blank for five doses from 10/2/09 to 10/21/09. It was noted the days the October 2009 MARs were not initialed were interspersed with days the medication was documented as not available. Avodart 0.5 mg, one time a day at 8:00 PM (for prostate enlargement). The medication technicians left the October MAR blank for seven doses from 10/1/09 to 10/20/09. The documentation does not confirm the medication was given to the resident. Namenda 10 mg, two times a day at 8:00 AM and 8:00 PM (for moderate to severe Alzheimer's related dementia/slows memory loss).	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 34 The medication technicians left the October MAR blank for 10 doses from 10/1/09 (8:00 PM) to 10/20/09 (8:00 PM). The documentation does not confirm the medication was given to the resident. Metformin 500 mg, two times a day at 8:00 AM and 8:00 PM (for blood sugar control/diabetes). The medication technicians left the October MAR blank for 11 doses from 10/1/09 (8:00 PM) to 10/20/09 (8:00 PM). The documentation does not confirm the medication was given to the resident. Aricept 10 mg, one time a day (for mild to moderate dementia) The medication technicians left the October MAR blank for six doses from 10/1/09 to 10/20/09. The documentation does not confirm the medication was given to the resident. Risperidone 0.5 mg, one time a day at noon (an antipsychotic). The medication was not available in the facility on 10/20/09. The medication technicians noted on the October MAR the medication was not available in the facility for 15 doses (10/1/09, 10/4/09, 10/5/09, 10/6/09, 10/7/09, 10/8/09, 10/11/09, 10/12/09, 10/ 13/09, 10/14/09, 10/15/09, 10/16/09, 10/18/09, 10/19/09, and 10/20/09). The medication technicians left the October MAR blank for five doses from 10/2/09 to 10/21/09. It was noted the days the October 2009 MARs were not initialed were interspersed with days the medication was documented as not available. Resident #8: Hydrocodone with APAP 5-500 mg, as needed	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 35 (for pain). During the medication review on 10/20/09, the medication was not available in the facility if needed by the resident. Seroquel 50 mg, two times a day at 8:00 AM and 8:00 PM (an antipsychotic) The medication technicians left the October MAR blank for three doses from 10/17/09 (8:00 AM) to 10/21/09 (8:00 AM). The documentation does not confirm the medication was given to the resident. Depakote 250 mg, two times a day at 8:00 AM and 8:00 PM (for seizure control). The medication technicians left the October MAR blank for three doses from 10/17/09 (8:00 AM) to 10/21/09 (8:00 AM). The documentation does not confirm the medication was given to the resident. Phenytoin Sodium 100 mg, one time a day at 8:00 PM (for seizure control). The medication technicians left the October MAR blank for four doses from 10/15/09 to 10/20/09. The documentation does not confirm the medication was given to the resident. Resident #9: Norvasc 5 mg, one time a day at 8:00 PM (for high blood pressure). The medication was not available in the facility on 10/20/09. The medication technicians left the October MAR blank for two doses on 10/17/09 and 10/21/09. The documentation does not confirm the medication was given to the resident. Namenda 10 mg, two times a day in the AM and PM (for moderate to severe Alzheimer's related dementia).	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 36 The medication technicians left the October MAR blank for five doses from 10/15/09 (PM) to 10/21/09 (AM). The documentation does not confirm the medication was given to the resident. Depakote 500 mg, three times a day at 8:00 AM, 12:00 PM and 4:00 PM (for seizure control) The medication technicians left the October MAR blank for eight doses from 10/15/09 (4:00 PM) to 10/21/09 (12:00 PM). The documentation does not confirm the medication was given to the resident. Zyprexa 5 mg, one time a day at bedtime (an antipsychotic). The medication technicians left the October MAR blank for three doses from 10/15/09 to 10/20/09. The documentation does not confirm the medication was given to the resident. Resident #10: Aricept 10 mg, one time a day at 6:00 PM (for mild to moderate dementia). The medication technicians left the October MAR blank for five doses from 10/1/09 and 10/20/09. The documentation does not confirm the medication was given to the resident. Docusate Sodium 100 mg, as needed (for constipation). During the medication review on 10/21/09, the medication was not available in the facility if the resident needed it. Ranitidine HCL 150 mg, two times a day at 8:00 AM and 8:00 PM (to reduce stomach acid). The medication technicians left the October MAR blank for eleven doses from 10/1/09 (8:00 PM) to 10/20/09 (8:00 PM). The documentation does not confirm the medication was given to the resident.	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 37 Resident #11: Levoxyl 0.025 mg, one time a day (thyroid hormone replacement). The medication was not available in the facility on 10/20/09. The medication technicians noted on the October MAR the medication was not available in the facility for three doses (10/15/09, 10/18/09 and 10/19/09). The medication technicians left the October MAR blank for one dose on 10/20/09. The documentation does not confirm the medication was given to the resident. Lisinopril 5 mg - one tablet by mouth every day (for high blood pressure). The medication technicians noted on the October MAR the medication was not available in the facility for seven doses on 10/27/09, 10/28/09, 10/29/09, 10/30/09, 10/31/09, 11/1/09, and 11/2/09. Hydralazine 50 mg, two times a day (for high blood pressure). The medication technicians left the October MAR blank for four doses from 10/17/09 (AM) to 10/21/09 (AM). The documentation does not confirm the medication was given to the resident. Torsemide 20 mg one tablet by mouth twice a day (for fluid retention). There was a discrepancy between the October 2009 MAR and the prescription bottle. The prescription bottle indicated the resident was to take one tablet twice a day. The MAR indicated the resident was to take one tablet every day. The facility needed to clarify the doctor's order. As of 10/23/09, the resident's physician put all	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 38 medications on hold except for Demadex, Lisinopril and Aspirin. Demadex 20 mg, two times a day (for high blood pressure). The medication technicians left the October MAR blank for four doses from 10/17/09 (AM) to 10/21/09 (AM). The documentation does not confirm the medication was given to the resident. On 10/26/09, the medication technician noted the resident did not receive the PM dose as the resident was "asleep." There was a discrepancy between the October 2009 MAR and prescription bottle label. The bottle label indicated the resident was to receive one tablet by mouth twice a day but the MAR indicated the resident was to receive one tablet daily. On 11/2/09, the medication technician reported she was administering the medication based on the MAR instructions, one tablet daily. Lisinopril 5 mg one tablet by mouth every day (for high bold pressure). The medication technicians noted on the October and November MARs the medication was not available in the facility for eight doses (10/27/09, 10/28/09, 10/29/09, 10/30/09, 10/31/09, 11/1/09, and 11/2/09). On 10/26/09, the medication technician noted the resident did not receive the daily dose as the resident was "asleep." This was the day before the medication was documented as not being available in the facility. During the medication review on 11/2/09, the medication was not available in the facility.	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 39 Aspirin 81 mg - one tablet every day (blood thinner). On 10/26/09, the medication technician noted the resident did not receive the daily dose as the resident was "asleep." The medication technicians left the October MAR blank for one dose on 10/29/09 and documentation did not confirm the medication was given to the resident. Resident #13: Ativan 1 mg (for anxiety) There was a discrepancy between the prescription bottle label which indicated the resident was to take 1 mg, three times a day, and the October 2009 MAR that indicated the medication was to be taken "as needed." Advair 100/50 (for asthma and chronic obstructive pulmonary disease (COPD). The November 2009 MAR indicated the resident was to inhale one puff twice daily. The medication technician reported the medication was "as needed." Celexa 30 mg one tablet each day (for depression). There was a discrepancy between the prescription bottle label which indicated the resident was to take 1 ½ tablets every day and the October MAR that indicated one tablet per day. The medication technicians left the October MAR blank for two doses from 10/25/09 to 10/26/09. The documentation does not confirm the medication was given to the resident. Coumadin 2.5 mg (a blood thinner). There was a discrepancy between the prescription bottle label which indicated the resident was to take one tablet per day, and the October and November	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 40 2009 MARs. The MARS indicated the resident was to take one tablet every other day and two tablets (5.0 mg) on the opposite days. The Executive Director reported the medication technicians were following the MAR and giving the medication on the alternating schedule. However, medication technicians were inconsistent with the delivery of this medication, giving the resident the 2.5 dose two days in a row four times in October. The medication technicians documented the medication was unavailable for two doses: - one dose on 10/23/09 - one dose on 10/24/09 Lasix 20 mg take one tablet every day (reduces fluid retention in edema and high blood pressure). The medication technicians noted on the October and November MARs the medication was not available in the facility for seven doses (10/27/09, 10/28/09, 10/29/09, 10/30/09, 10/31/09, 11/1/09 and 11/2/09). Lopressor 25 mg, two times a day (for high blood pressure). The medication technicians noted on the October and November MARs the medication was not available in the facility for 29 doses: - one dose on 10/12/09 (AM) - two doses on 10/15/09 (AM and PM) - one dose on 10/17/09 (AM) - one dose on 10/18/09 (AM) - two doses on 10/19/09 (AM and PM) - two doses on 10/20/09 (AM and PM) - one dose on 10/21/09 (AM) - two doses on 10/24/09 (AM and PM) - two doses on 10/25/09 (AM and PM) - two doses on 10/26/09 (AM and PM) - two doses on 10/27/09 (AM and PM)	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 41 - two doses on 10/28/09 (AM and PM) - two doses on 10/29/09 (AM and PM) - two doses on 10/30/09 (AM and PM) - two doses on 10/31/09 (AM and PM) - two doses on 11/1/09 (AM and PM) - one dose on 11/2/09 (AM) The medication technicians noted on the October MAR that the resident "refused" the medication on four occasions: 10/2/09 (PM), 10/12/09 (PM), 10/17/09 (PM) and 10/18/09 (PM). Lortab 10/500 take one tablet by mouth every 8 hours as needed (for moderate to severe pain). The medication technicians noted on the October MARs the medication was not available in the facility if the resident needed it for three days (10/24/09, 10/25/09 and 10/26/09). Megace 400 mg, two times a day (for loss of appetite). The October and November MARs indicated the medication was to be taken two times daily, however only the morning (AM) dosage was documented by medication technicians on the MARs. The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/20/09. SOMA (a muscle relaxer): There was a discrepancy between the prescription bottle, which contained 350 mg tablets to be given three times a day, versus the October and November 2009 MARs that listed 300 mg tablets to be given every eight hours "as needed." On 11/2/09, the medication technicians reported the medication was being administered "as needed."	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 42 The October MAR also revealed the following inconsistencies with medications on hand: - Omeprazole (for stomach acid), Singular (for allergies) and Wellbutrin (for depression) were available and administered per a medication technician, but were not listed on the October MAR. Resident #15: Risperidone .25 mg take one tablet by mouth at bedtime (an antipsychotic) The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/27/09. Resident #16: Temazepam as needed (for insomnia). The medication was available but was not listed on the November MAR. A medication technician reported giving the medication to the resident. Lasix/Furosemide (reduces fluid retention in edema or high blood pressure). There was a discrepancy between the prescription bottle label which indicated the resident was to receive a 40 mg tablet every day and the October and November MARs which listed 1/2 tablet (20 mg) every day. Based on medication technician MAR documentation, the resident received 20 mg by mouth every day in October and two days in November. On 11/2/09, Employee #8 called the pharmacy and confirmed that Resident #17 should have been receiving 40 mg per day. Klor-Con (a potassium replacement used in conjunction with Lasix). There was a discrepancy between the prescription bottle label which indicated the resident was to receive one 20 milliequivelants (meq) tablet every day and the October and November MARs listed 1/2 tablet	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 43 (10 meq) every day. Employee #3 stated resident received 1/2 tablet by mouth each day in October and for two days in November. On 11/2/09, Employee #8 called the pharmacy and confirmed that Resident #17 should have been receiving 20 meq per day. Resident #17: Amlodipine 2.5 mg (for high blood pressure) and Naproxen (for pain and inflammation) 300 mg. On 10/21/09, the medications were in with the resident's other medications and a medication technician reported the medications were being administered to the resident. The medications were not listed on the October or November MARs. Hydrocodone 5-500 mg one tablet at 10:00 AM, 3:00 PM, and 8:00 PM (for moderate to severe pain). The medication technicians noted on the October MAR the medication was not available in the facility for four doses: - two doses on 10/23/09 (3:00 PM and 8:00 PM) - two doses on 10/24/09 (3:00 PM and 8:00 PM) The medication technicians left the October MAR blank for two doses on 10/24/09 (10:00 AM) and 10/25/09 (10:00 AM). It was noted the days the October 2009 MAR was not initialed were interspersed with days the medication was documented as not available. Without documentation, it is not clear whether the medication was also unavailable on these dates or was not given for some other reason. Zolpidem 5 mg take one tablet at bedtime (for insomnia). The medication technicians noted on the October MAR the medication was not available in the facility for 21 doses (10/1/09, 10/2/09, 10/3/09,	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 44 10/4/09, 10/5/09, 10/6/09, 10/7/09, 10/8/09, 10/9/09, 10/10/09, 10/11/09, 10/12/09, 10/17/09, 10/18/09, 10/20/09, 10/21/09, 10/23/09, 10/24/09, 10/25/09, 10/26/09 and 10/27/09). Methadone HCL 10 mg take 1 tablet at 2:00 PM and 7:00 PM (for severe pain). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/26/09 (2:00 PM Medication technician noted "methadone absent at 3:00 pm"). Resident #18: Albuterol /Atrovent SVN, nebulizer treatment four times a day as needed for shortness of breath (reduces bronchospasms in asthma or COPD). The medication was not available in the facility on 10/21/09. No doses were documented as given on the October MAR. Pantoprazole Sod 40 mg, one time a day (to reduce stomach acid). The medication technicians noted on the October MAR the medication was not available in the facility for 12 doses (10/3/09, 10/4/09, 10/5/09, 10/11/09, 10/12/09, 10/13/09, 10/14/09, 10/15/09, 10/18/09, 10/19/09, 10/20/09 and 10/21/09). Prozac 20 mg, one time a day (for depression). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/12/09. Multivitamin, one time a day. The medication technicians noted on the October MAR the medication was not available in the facility for four doses (10/18/09, 10/19/09, 10/20/09 and 10/21/09). .	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 45 Metoprolol 50 mg, one time a day (for high blood pressure). The medication technicians noted on the October MAR the medication was not available in the facility for three doses (10/19/09, 10/20/09 and 10/21/09). Resident #19: Aldara 5 %, apply at bedtime (for skin conditions/skin cancer). The medication technicians noted on the October MAR the medication was not available in the facility for three doses (10/13/09, 10/17/09 and 10/18/09). Avodart Softgel 0.5 mg, one time a day (reduces bronchospasms in asthma or COPD. The medication technicians noted on the October MAR the medication was not available in the facility for 20 doses from 10/13/09 to 11/2/09. Tylenol #3 as needed (for moderate to severe pain). The medication was not available in the facility on 11/2/09 if it was needed by the resident. Lipitor 20 mg, one tablet by mouth daily (for high cholesterol). - four doses missed (including 11/1/09). On 11/2/09, Employee #3 stated the October 2009 MAR was initialed for 10/29/09, 10/30/09, 10/31/09 but the medication was not available in the facility and had been since 10/29/09. Simvastatin 20 mg, one tablet by mouth in the evening (for high cholesterol) - four doses missed (including 11/1/09). On 11/2/09, Employee #3 stated the October 2009 MAR was initialed for 10/29/09, 10/30/09 and 10/31/09 but the medication was not available in	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 46 the facility and had been since 10/29/09. Resident #20: Namenda 10 mg, two times a day (for moderate to severe Alzheimer ' s related dementia). The medication technicians noted on the October MAR the medication was not available in the facility for 28 doses: - one dose on 10/1/09 (PM) - one dose on 10/3/09 (PM) - one dose on 10/4/09 (PM) - one dose on 10/5/09 (PM) - two doses on 10/6/09 (AM and PM) - two doses on 10/7/09 (AM and PM) - one dose on 10/8/09 (PM) - one dose on 10/9/09 (PM) - one dose on 10/10/09 (PM) - two doses on 10/11/09 (AM and PM) - two doses on 10/12/09 (AM and PM) - two doses on 10/13/09 (AM and PM) - two doses on 10/14/09 (AM and PM) - one dose on 10/15/09 (AM) - one dose on 10/17/09 (PM) - two doses on 10/18/09 (AM and PM) - two doses on 10/19/09 (AM and PM) - two doses on 10/20/09 (AM and PM) - one dose on 10/21/09 (AM) - two doses on 10/25/09 (AM and PM) - two doses on 10/26/09 (AM and PM) - two doses on 10/27/09 (AM and PM) - two doses on 10/28/09 (AM and PM). The medication was delivered 10/29/09. It was noted that the days the medication technicians noted the medication was given on the October 2009 MAR were interspersed with days the medication was documented as not available. Novolin N, two times a day (insulin for diabetes)	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 47 During the medication review on 10/21/09, the medication was not available in the facility. Hydralazine 25 mg two times a day (for high blood pressure). The medication technicians noted on the October MAR the medication was not available in the facility for 23 doses: - one dose on 10/1/09 (PM) - one dose on 10/3/09 (PM) - one dose on 10/4/09 (PM) - one dose on 10/5/09 (PM) - one dose on 10/6/09 (PM) - one dose on 10/7/09 (PM) - one dose on 10/8/09 (PM) - one dose on 10/9/09 (PM) - one dose on 10/10/09 (PM) - two doses on 10/11/09 (AM and PM) - one dose on 10/12/09 (AM) - one dose on 10/13/09 (AM) - two doses on 10/14/09 (AM and PM) - two doses on 10/15/09 (AM and PM) - one dose on 10/17/09 (PM) - two doses on 10/18/09 (AM and PM) - two doses on 10/19/09 (AM and PM) - one dose on 10/21/09 (AM) It was noted on the October 2009 MAR that the days the medication was initialed as given were interspersed with days the medication was documented as not available. Levobunolol 0.25% one drop in both eyes daily (for glaucoma). During the medication review on 10/21/09, the medication was not available in the facility. The medication technicians noted on the October MAR the medication was not available in the facility for three doses on 10/25/09, 10/26/09 and 10/27/09.	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 48 The medication technicians left the October MAR blank for one dose on 10/24/09. The documentation does not confirm the medication was given to the resident. Acetaminophen 500 mg two tablets by mouth every six hours as needed (for pain). On 11/2/09, the medication was found in with the resident's other medications and it was not listed on the November MAR. A medication technician reported the resident was not taking this medication. If the medication was discontinued by the resident's physician, it had not been destroyed. If the medication was to remain available in the facility, it should have been listed on the MAR. Promethazine 25 mg ½ tablets four times a day as needed (for nausea or vomiting). On 11/2/09, the medication was found in with the resident's other medications and it was not listed on the November MAR. A medication technician reported on 11/2/09 that the resident continues to take this medication. The medication should have been listed on the MAR. Metoclopramide 10 mg one tablet before meals and at bedtime (for nausea or vomiting). On 11/2/09, the medications was in with the resident's other medications and it was not listed on the November MARs. If the medication was discontinued by the resident's physician, it had not been destroyed. If the medication was to remain available in the facility, it should have been listed on the MAR. Resident #22: The resident's October 2009 MAR up to 10/21/09 was reviewed. On 10/11/09, the caregivers documented the resident was, "Very agitated " On 10/14/09, the resident went to the	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 49 memory care unit. On 10/21/09, the caregivers documented the resident, "Became combative" and the resident was sent to the hospital. Carbidopa/Levodopa 50-200 mg, three times a day (for Parkinson's disease). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/2/09 (PM). Ropinirole 2 mg, three times a day (for Parkinson's disease). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/2/09 (PM). Resident #23: Azithromycin 250 mg, one time a day (an antibiotic). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/6/09. Resident #25: Aricept 5 mg, one time a day (for mild to moderate dementia). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/1/09. Fosamax 70 mg, one tablet every Sunday (for osteoporosis). The medication technicians noted on the October MAR the medication was not available in the facility for two doses on 10/4/09 and 10/11/09. The medication was not available in the facility during the survey on 10/21/09. Sertraline 100 mg, one time a day (for depression).	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 50 The medication technicians noted on the October MAR the medication was not available in the facility for four doses on 10/4/09, 10/9/09, 10/11/09 and 10/26/09. The medication technicians left the October MAR blank for five doses from 10/27/09 to 10/31/09. The documentation does not confirm the medication was given to the resident. Vesicare 5 mg, one time a day (for an overactive bladder). The medication technicians noted on the October MAR the medication was not available in the facility for ten doses (10/1/09 through 10/11/09). The medication technicians left the October MAR blank for six doses from 10/26/09 to 10/31/09. The documentation does not confirm the medication was given to the resident. Atrovent inhaler (for asthma or COPD): There was a discrepancy between the medication prescription which indicated the resident was to receive one puff two times a day, and the October MAR that listed one puff one time a day. The medication was not listed on the November 2009 MAR. The medication technicians documented the medication was not given for five doses on 10/25/09, 10/26/09, 10/27/09, 10/28/09, and 10/31/09. Resident #28: Tylenol ES 500 mg take two tablet twice a day (for pain). The medication technicians noted on the October MAR the medication was not available in the facility for 17 doses: - three PM doses (10/23/09, 10/24/09, 10/25/09) - two doses on 10/26/09 (AM and PM) - two doses on 10/27/09 (AM and PM)	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 51 - two doses on 10/28/09 (AM and PM) - two doses on 10/29/09 (AM and PM) - two doses on 10/30/09 (AM and PM) - two doses on 10/31/09 (AM and PM) - one dose on 11/1/09 (AM) - one dose on 11/2/09 (AM) The medication was not available in the facility on 11/2/09. Exelon Patch 9.5 mg, one time a day (for mild to moderate Alzheimer's related dementia/slow memory loss) The medication technicians noted on the October MAR the medication was not available in the facility for six doses (10/1/09, 10/13/09, 10/14/09, 10/16/09, 10/17/09 and 10/18/09). Lisinopril 20 mg, one time a day (for high blood pressure). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/1/09. Methotrexate 2.5 mg, four tabs every Thursday (cancer treatment). The medication technicians noted on the October MAR the medication was not available in the facility for one dose on 10/1/09. Tylenol ES 500 mg, two tablets by mouth twice a day (for pain). The medication was not available in the facility on 10/22/09 or on 11/2/09. The medication technicians noted on the October MAR the medication was not available in the facility for 17 doses: - one dose on 10/23/09 (PM) - one dose on 10/24/09 (PM) - one dose on 10/25/09 (PM) - two doses on 10/26/09 (AM and PM)	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 52 - two doses on 10/27/09 (AM and PM) - two doses on 10/28/09 (AM and PM) - two doses on 10/29/09 (AM and PM) - two doses on 10/30/09 (AM and PM) - two doses on 10/31/09 (AM and PM) - one dose on 11/1/09 (AM) - one dose on 11/2/09 (AM) This was a repeat deficiency from the 9/24/09 Complaint Investigation. Severity: 4 Scope: 1	Y 878		
Y 883 SS=E	449.2742(7) Medication / Resident Refusal NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed. This Regulation is not met as evidenced by: Surveyor: 28380 Based on record review and interviews on 10/20/09, the facility had no evidence physicians were notified within 12 hours when 6 of 30 residents refused medications (Residents #4, #5, #6, #11, #13, and #22). Findings include: October 2009 medication administration (MAR) records for 30 residents were reviewed. The MARs indicated that six residents refused	Y 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 883	Continued From page 53 medications. Documentation that the facility notified the physicians caring for those residents was not located in the records. A caregiver was interviewed regarding the notification of physicians when residents refused their medications. The caregiver reported they called and left messages with physician offices, but could not provide any documentation of these phone calls. Severity: 2 Scope: 2	Y 883		
Y 890 SS=C	449.2744(1)(a)(1)-(4) Medication / Receipt Log NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility. (2) The date of its delivery; (3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medications is removed from the facility or destroyed. This Regulation is not met as evidenced by:	Y 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 890	Continued From page 54 Surveyor: 11456 Based on interview and record review from 10/20/09 to 11/2/09, the facility failed to maintain a log for each resident medication received by the facility from 10/1/09 to 10/21/09. Severity: 1 Scope: 3	Y 890		
Y 895 SS=I	449.2744(1)(b)(1) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Surveyor: 28380 Based on record review and interviews from	Y 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 895	Continued From page 55 10/20/09 through 11/2/09, the facility failed to ensure the computerized medication administration records (MAR) were consistent for 30 of 30 residents receiving medication assistance in September, October and November 2009(Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29 and #30); and accurate for 18 of 30 residents (Resident #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #16, #17, #19, #20, #21, #25 and #26). Findings include: During the complaint investigation and re-survey, it was determined 18 of the 30 resident medication records between 10/2/09 through 11/2/09 had significant medication errors. The facility was using a computerized MAR system in which caregivers entered their initials to document when the medications were administered or used numerical codes for when medications were refused, were not available, were discontinued, were administrated late, were not administered because the resident was in the hospital or was asleep. The September and October 2009 MARs for residents receiving medication assistance were reviewed. It was noted the numerical codes were not consistent between MARs. For example, code 1 was used for a medication that was not available for one resident (Resident #22), but the same code was also used to document that another resident was absent (Resident #20). The computerized September and October MARs also had days that contained no documentation that medications were administered to residents between 10/1/09 through 11/2/09. It was discovered during interviews the computer	Y 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 11/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 895	Continued From page 56 system failed regularly and on those days, caregivers had to document on printed paper MARs that they administered the medications. On 10/24/09, it was noted that in the memory care unit, the computer had been removed and caregivers were hand writing medication administration on photocopies of the computerized MARs. The memory care unit caregivers admitted there was no place on the photocopied MARs to document when they administered as-needed medications. Interview with the Executive Director, Employee #1, on 10/24/09 revealed the facility implemented printed paper MARs for all residents in the assisted living section of the building as of 10/23/09 at midnight. A review of the paper MARs on 10/24/09 at noon revealed the paper MARS were not being used by medication technicians and staff reported they had not received instructions to use the paper MARS. The Executive Director was notified and she reported she would ensure staff started to use the paper MARs instead of the computerized MARs. A review of the paper MARS on 10/25/09 at 10:16 AM showed evening staff had initialed for the PM medications on 10/24/09, but the 10/25/09 morning staff had not for the AM medications. This showed the continued lack of consist practices by the facility and its management. (Refer to TAG Y878) Severity: 3 Scope: 3	Y 895		